AUGUST 2022 HIGHLIGHTS

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Former VA Social Worker Claiming to Be a Purple Heart and Bronze Star Recipient Pleaded Guilty for Stolen Valor Scheme That Included Stealing a Veteran's Identity to Gain Benefits

A former social worker at the Providence VA Medical Center in Rhode Island fraudulently claimed to be a wounded US Marine Corps veteran who was the recipient of a Purple Heart and a Bronze Star. The defendant collected more than $250,000 in benefits from veteran-focused charities using the personally identifiable information of an actual Marine to falsely claim she served in the Marine Corps from 2009 to 2016, achieved the rank of corporal, was wounded in action, and was honorably discharged. The defendant also falsely claimed to have cancer due to her alleged military service after using her position to access the VA medical records of a veteran cancer patient. The former social worker pleaded guilty in the District of Rhode Island to wire fraud, aggravated identify theft, fraudulent representations about receipt of military medals or decorations, and forging military or naval discharge documents. This investigation was conducted by the VA OIG, FBI, Defense Criminal Investigative Service (DCIS), US Postal Inspection Service (USPIS), Naval Criminal Investigative Service, VA Police Service, and Internal Revenue Service Criminal Investigation.

Pharmacy Executive and Assistant Sentenced to Prison for $88 Million Compounding Pharmacy Scheme

A private sector pharmacy executive and his executive assistant conspired with others to fraudulently bill TRICARE and CHAMPVA for expensive, medically unnecessary compounded medications. In furtherance of the scheme, the coconspirators paid approximately $40 million in kickbacks to patients, patient recruiters, and doctors. The medications, which were ordered in excessively large quantities, were formulated to maximize profit without legitimate therapeutic value. The coconspirators also used phony charities to conceal that the pharmacy did not charge the patients for mandatory copayments. The fraudulent patient referrals caused a loss to TRICARE and CHAMPVA of approximately $88 million that should have been used to benefit service members and veterans' spouses and children eligible for VA healthcare with legitimate medication needs. Of this amount, the loss to VA is more than $757,000. The executive and executive assistant were sentenced in the Southern District of Florida to 90 months

and 60 months in prison, respectively, and ordered to pay joint restitution of $75.1 million. The VA OIG, FDA Office of Criminal Investigations, DCIS, and FBI conducted the investigation.

Defendant Sentenced in Connection with Kickback Scheme

Two laboratories allegedly engaged in a kickback scheme involving marketers and physicians that resulted in approximately $300 million in losses to the government. The laboratories, through marketers, allegedly paid hundreds of thousands of dollars to doctors for "advisory services" that were never performed in return for laboratory test referrals. One defendant was sentenced in the Northern District of Texas to 18 months in prison, three years of supervised release, and restitution of close to $650,000 after previously pleading guilty. The VA OIG, FBI, Department of Health and Human Services (HHS) OIG, and DCIS carried out this investigation.

Former Kerrville VA Medical Center Pharmacy Technician Sentenced for Drug Diversion Scheme

A former pharmacy technician stole over 40 packages containing controlled substances intended for veterans from mailboxes in and around Kerrville, which he subsequently sold to accomplices for further distribution. He was sentenced in the Western District of Texas to 12 months in prison and 36 months of supervised release. The investigation was performed by the VA OIG, Drug Enforcement Administration, Kerr County Sheriff's Office, and USPIS.

Former Purchasing Agent at the Jesse Brown VA Medical Center Pleaded Guilty to Wire Fraud

A VA OIG investigation revealed that between 2017 and 2020, a former purchasing agent at the Jesse Brown VA Medical Center in Chicago, Illinois, conspired to purchase medical supplies from a vendor in exchange for kickbacks of at least $220,000. The vendor received about $2.8 million in VA purchase card orders from the defendant, of which approximately $1.38 million are alleged to have been fraudulent. The former employee pleaded guilty in the Northern District of Illinois to wire fraud.

Benefits Investigations

Private Helicopter Flight Instructor Training Company and a Community College Agree to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that a private helicopter flight instructor training company and a community college violated the False Claims Act by making false statements to VA in connection with their jointly operated training program. To qualify for Post 9/11 GI Bill funding, a school is required to certify to VA that no more than 85 percent of the students for any particular course are receiving VA benefits. This requirement, commonly referred to as the "85/15 rule," is intended to prevent abuse of GI Bill funding by ensuring that VA is paying fair market value tuition rates since at least 15 percent of the students would be paying the same rate with non-VA funds. The investigation alleges that the defendants falsely certified compliance with the 85/15 rule because the flight instructor program included certain expensive classes that were taken almost exclusively by veterans. To reach the

required 15 percent threshold, the community college allegedly counted part-time students enrolled in only one online class per semester as full-time students, in violation of VA rules. The defendants agreed to pay $7.5 million to resolve these allegations. Of this amount, the helicopter company agreed to pay $7 million and the community college agreed to pay $500,000. The investigation was conducted by the VA OIG, US Attorney's Office for the District of Kansas, and the Fraud Section of the Department of Justice Civil Division's Commercial Litigation Branch.

Former Barber School Owner Sentenced for Fraudulently Collecting GI Bill Funds

From approximately October 2016 to March 2019, the former owner of a barber school offered a master course that was not accredited and approved by the state's Board of Barber Examiners. The defendant fraudulently represented that this course was approved, which resulted in his collection of GI Bill funds from veterans enrolled in the program. He was sentenced in the Southern District of Mississippi to one year and one day imprisonment, three years of supervised release, and restitution of over $402,000 after previously pleading guilty to wire fraud.

Three Defendants Guilty of Compensation Benefits Fraud Scheme

A VA OIG and Social Security Administration (SSA) OIG investigation resulted in charges alleging multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. One defendant allegedly received about $35,000 in SSA disability insurance benefits for her claimed disabilities. Two defendants previously pleaded guilty to conspiracy and theft of government property, while a third defendant was convicted at trial in the District of Maryland of the same charges. The loss to VA is approximately $820,000.

Veteran Found Guilty for Misrepresenting Symptoms to Obtain Compensation Benefits

A hotline complaint to the VA OIG alleged that a veteran misrepresented symptoms of conversion disorder (a functional neurological system disorder) and choreiform gait disorder (irregularly and involuntary movements exhibited when walking) to obtain a 100 percent service-connected disability rating, VA Aid and Attendance benefits, and VA Survivors' and Dependents' Educational Assistance. The total estimated loss to the government is about $567,000. Of this amount, the loss to VA is close to $423,000. The VA OIG and SSA OIG completed this investigation. The veteran was then found guilty at trial by a federal jury in the District of Kansas of wire fraud and theft of government funds.

Defendant Admitted to Fraudulently Obtaining VA Benefits in Deceased Mother's Name

From 1973 through 2021, the daughter of a deceased VA beneficiary signed her late mother's name on the back of her VA checks and forged her name on documents submitted to VA. The defendant also forged her mother's signature on a form that directed VA to deposit the benefits into a bank account that she controlled. When filing for bankruptcy, the defendant also falsely claimed that she had no income when at that time she was fraudulently receiving monthly VA benefits intended for her mother. The total loss to VA is approximately $462,000. The defendant pleaded guilty in the Southern District of Ohio to theft of government funds. The investigation was conducted by the VA OIG.

Veteran Sentenced for Lying about Impairment

Following a hotline complaint, a VA OIG investigation brought to light that a veteran exaggerated his mental and physical impairments to fraudulently increase his VA compensation benefits. The veteran lied on a mental health test by reporting to VA that he had been in combat, qualifying him for posttraumatic stress disorder benefits. Investigators confirmed that the veteran was a competitive bodybuilder who faked physical ailments to VA examiners, including using a cane at the VA medical center and telling examiners he could not lift more than 10 to 20 pounds. The veteran was sentenced in the Southern District of Florida to one year of imprisonment, three years of supervised release, and restitution of about $246,000 after previously pleading guilty to theft of government funds.

US Postal Employee Sentenced for Making False Statements about His Income

A US Postal Service employee who previously served in the Army failed to disclose his employment to VA when he applied for monthly pension benefits in 2011. According to VA OIG investigators, despite earning more than $65,000 per year, the veteran signed and certified an application for VA pension benefits in which he falsely reported that he had no income. The veteran also reported that his home was his only asset and that he had a medical condition that prevented him from working. After approving this application, VA paid pension benefits to the veteran from 2011 to 2020. He was sentenced in the Southern District of Georgia to three years of probation and ordered to pay restitution of more than $244,000 after having pleaded guilty to false statements.

Investigations Involving Other Matters

Global Healthcare Company to Pay $6.3 Million to Resolve False Claims Act Allegations

The VA OIG, Army Criminal Investigation Division, and HHS OIG investigated allegations that a global health company violated the False Claims Act by selling items to the United States that were manufactured in nondesignated countries in violation of the Trade Agreements Act of 1979. From 2012 through 2019, the company allegedly sold medical supplies manufactured in nondesignated countries to VA that were valued at approximately $42.5 million. Noncompliant medical supplies were also allegedly sold to HHS and the Department of Defense that were respectively valued at $11.5 million and $7.1 million. The company entered into a settlement under which it agreed to pay $6.3 million to resolve these allegations.

Two Defendants Found Guilty in Connection with Service-Disabled Veteran-Owned Small Business Scheme

A VA OIG, Small Business Administration (SBA) OIG, and Department of Interior OIG investigation based upon a hotline complaint resulted in charges alleging that two nonveterans managed and controlled a service-disabled veteran-owned small business to fraudulently obtain federal set-aside contracts. The small business allegedly made numerous false statements to SBA and provided fraudulent references to VA for past work performance to obtain federal contracts. The two nonveterans were found guilty at trial in the Eastern District of Tennessee of conspiracy to commit wire fraud, wire fraud,

and major fraud against the United States. The total loss to the government is approximately $14.8 million. Of this amount, the total loss to VA is approximately $3.8 million.

Licensed Practical Nurse at the Northampton VA Medical Center in Massachusetts Indicted for Distribution and Possession of Child Pornography

A VA OIG, US Secret Service, and VA Police Service investigation resulted in charges alleging that a licensed practical nurse at a VA medical center in Leeds, Massachusetts, used the facility's public Wi-Fi to upload and download thousands of files to his personal computer that contained child pornography. The nurse was indicted in the District of Massachusetts on charges of distribution and possession of child pornography.

Veteran Arrested for Allegedly Shooting at VA Medical Center in Connecticut

In May 2021, a veteran allegedly discharged a .22 caliber long rifle from his vehicle, striking the eastern façade of the West Haven VA Medical Center approximately 15 times, which resulted in damage totaling more than $470,000. The veteran has also been criminally charged with 10 other shootings that occurred on that same day at multiple residences, a church, and the State Capitol building in Hartford, Connecticut. He was arrested after being charged in Connecticut Superior Court with criminal mischief in the first degree. The VA OIG, West Haven Police Department, and VA Police Service investigated.

Former VA Patient Advocate Indicted for Physically Assaulting a Veteran

According to a VA OIG investigation, a former supervisory patient advocate at the Fort McPherson VA Clinic in Atlanta, Georgia, allegedly attacked a veteran who was seeking advocacy assistance, causing serious injuries. The former patient advocate was arrested after being indicted in Fulton County (Georgia) Superior Court on charges of elder abuse, aggravated battery, aggravated assault, and aggravated assault strangulation.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to improve the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following reports this month.

Information Technology

VA Needs to Improve Governance of Identity, Credential, and Access Management Processes

Acting on another hotline complaint, the OIG reviewed whether VA was effectively governing its identity, credential, and access management (ICAM) processes and found that VA was not complying with Office of Management and Budget requirements. This was primarily because leaders of the

different offices performing VA's ICAM functions have not agreed on how it should be governed. Without proper governance, VA risks both restricting information from users who need it to perform their job functions and leaving information vulnerable to improper use. The OIG recommended the VA deputy secretary designate roles and responsibilities for all program offices involved in the ICAM process and ensure appropriate oversight and coordination. The OIG also recommended that the assistant secretary for information and technology and the assistant secretary for human resources and administration/operations, security, and preparedness update and publish the VA directives and handbooks associated with identity and access management, common employee identification standards, and VA's personnel security and suitability program.

Featured Report

Improved Processing Needed for Veterans' Claims of Contaminated Water Exposure at Camp Lejeune

From August 1953 through December 1987, the Agency for Toxic Substances and Disease Registry estimated one million individuals could have been exposed to contaminated drinking water at Camp Lejeune, a US military training facility. In March 2017, VA established a presumption of military service connection for eight illnesses related to veterans' exposure to that contaminated water. The OIG conducted this review to determine whether VBA staff followed regulations when processing and deciding claimed conditions potentially associated with contaminated water exposure at Camp Lejeune.

Based on a statistical sample, the OIG estimated that of 57,500 Camp Lejeune–related claims for VA disability compensation benefits decided during the review period (March 14, 2017–March 31, 2021), VBA staff incorrectly processed 21,000. The two main errors were prematurely denying claims (17,200) by not sending required letters to veterans requesting evidence needed to document exposure and assigning incorrect effective dates for benefit entitlement (2,300 claims). Approximately 1,500 additional incorrectly processed claims involved technical or procedural errors. Premature denial of claims increased the risk that some veterans did not receive the benefits to which they were entitled, and veterans were underpaid at least $13.8 million in benefits over nearly four years because VA regional office staff did not assign the earliest effective date for benefits entitlement.

The OIG found that errors were less likely to occur at the Louisville Regional Office, which processes most Camp Lejeune–related claims, as staff from other VA regional offices lacked experience processing these claims. The OIG recommended that VBA centralize all Camp Lejeune–related claims processing at the Louisville Regional Office or implement a plan to mitigate the error rate disparity with other regional offices. VBA should also conduct targeted quality reviews of Camp Lejeune–related claims from all regional offices processing these claims.

Benefits Delivery and Administration

The Fugitive Felon Benefits Adjustment Process Needs Better Monitoring

This review determined the VBA did not always adjust compensation and pension benefit payments for veterans who were fugitive felons. For example, VBA did not process fugitive felon cases in 2012 and 2013. Further, due to inadequate monitoring, it did not process about 46 percent of fugitive felon cases referred by the OIG in 2019 and 2020. As a result, some veterans may have received funds to which they were not entitled. In addition, due to a previously unnoted deficiency with VBA's automated letters, some veterans were not informed of their legal rights and potentially had their benefits improperly suspended. VBA concurred with the OIG's three recommendations to (1) review unprocessed felony referrals, (2) improve monitoring procedures, and (3) ensure necessary information is provided to veterans, and also provided information on the actions taken to address these recommendations. Based on information provided, the OIG considers recommendation two closed.

Digital Divide Consults and Devices for VA Video Connect Appointments

This audit evaluated the efficiency and effectiveness of VHA's digital divide consult process that provides eligible patients with video-capable devices (iPads). The review found the program was successful in distributing devices to patients but identified gaps in oversight and guidance involving unused and multiple devices and the purchase of new ones while others awaited refurbishment. VHA could have made better use of about $14.5 million with better controls and oversight. The OIG made 10 recommendations to the under secretary for health: alert the requesting clinic that a patient can be scheduled, ensure staff are trained on program changes, add procedures to address duplicate devices, designate responsible officials to monitor for appointment activity and device use, define lead oversight responsibilities, establish an automated report identifying unused devices, enhance tracking of device packages, and implement detailed device refurbishment reporting to inform new device purchases.

The Compensation Service Could Better Use Special-Focused Reviews to Improve Claims Processing

Given the importance of accurately deciding veterans' claims for disability benefits, VBA includes in its quality assurance efforts special-focused reviews that target specific topics, such as military sexual trauma claims. The OIG assessed VBA's design and implementation of its special-focused review process and identified weaknesses in all five of the Government Accountability Office's (GAO) internal control components when determining whether VBA had met GAO standards. The OIG determined that the standard operating procedure for special-focused reviews did not provide sufficient guidance to fully support claims-processing improvement—including requiring that the causes of identified errors be included in final reports. The OIG made six recommendations to the under secretary for benefits, including that VBA update the special-focused review standard operating procedure to require an analysis of why errors occurred and establish controls to ensure reports communicate both benefit entitlement and procedural errors and that corrective actions are taken on all errors.

Office of Special Reviews

This office conducts administrative investigations and increases the OIG's flexibility and capacity to conduct prompt reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. The Office of Special Reviews released the following report this month.

Alleged Unauthorized Access of a VA Senior Executive's Email Not Substantiated

The OIG investigated an allegation that an attorney at the Board of Veterans' Appeals (BVA) may have accessed a BVA senior executive's government email account without permission, including email concerning a personnel matter involving the attorney. The complaint further alleged that the attorney should have known that access to the materials in the executive's email account was not authorized. The allegations were not substantiated, and the attorney has since left VA employment.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Healthcare Inspections

Deficiencies in Life-Sustaining Treatment Processes at the Michael E. DeBakey VA Medical Center in Houston, Texas

This inspection substantiated an allegation that a community living center nurse at the medical center in Houston delayed life-sustaining treatment for a patient (Patient A) who was experiencing cardiac arrest and died, and that a second patient had resuscitation initiated by inpatient staff despite an active do not resuscitate (DNR) order. The team identified additional concerns related to the use of DNR armbands and the suspension of DNR orders in the operating room. The OIG made one recommendation to the under secretary for health to review DNR processes and five recommendations to the facility director related to staff (1) verifying in patients' electronic record any life-sustaining treatment orders and code statuses, (2) evaluating corrective actions from management reviews, (3) locating life-sustaining treatment orders within the health record, (4) modifying patients' life-sustaining treatment orders, and (5) reviewing patients' code statuses when they returned to facility units after surgical procedures.

Failure to Communicate and Coordinate Care for a Community Living Center Resident at the VA Greater Los Angeles Health Care System in California

The OIG assessed allegations that CLC nursing staff failed to assess a resident, document assessments or interventions, and implement the healthcare provider's order. The inspection team substantiated that a

nurse delayed an assessment and failed to document other assessments, interventions, and a telephone order to transfer the resident to the emergency department. The resident did not have needed equipment when admitted to the CLC and facility staff failed to conduct a comprehensive review of the events surrounding the resident's death. The VISN and facility directors concurred with the OIG's 10 recommendations, which included completing and documenting an institutional disclosure; reviewing policy and admission processes; and conducting training for CLC staff regarding documentation, assessments, procedures for managing verbal and telephone orders, hand-off communication policies, the joint patient safety report submission process, and administrative reviews.

Other Reports

Internal Investigation Regarding Unauthorized Possession of OIG-Issued Firearm

VA OIG attorney-advisors conducted this internal investigation, which was overseen by the deputy inspector general, following allegations of misconduct by OIG employees, including a former senior executive in the Office of Investigations. The senior executive was found to have possessed an OIG-issued firearm and special agent credentials without authorization after he assumed a deputy position within that office and was no longer a special agent. Other personnel were found to have been aware of these issues but did not take appropriate action. An administrative process was completed as to the personnel still employed with the OIG, along with other associated corrective actions. To promote transparency and accountability, the OIG publishes summaries of internal investigations concerning allegations of misconduct by its senior personnel. Summary information released is consistent with applicable privacy laws and regulations.

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